STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676477	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Mount Vernon	501 Yates Street Mount Vernon, TX 75457

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make a comprehensive assessment of each residents' needs, strengths, goals, life history, and preferences within 14 calendar days after admission for 1 of 13 residents (Resident #10) reviewed for accuracy of assessments. The facility failed to complete Resident #10's admission MDS assessment, with an ARD of 03/11/2025, within 14 days of admission. This failure could place residents at risk of not having their needs met. Findings included: Record review of a face sheet dated 06/11/2025 indicated Resident #10 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and paralysis affecting the left side after a stroke) and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #10's comprehensive MDS assessment with an ARD of 03/11/2025 indicated in Section A0310 it was an admission assessment (required by day 14). The MDS assessment for Resident #10 indicated in Section A1600 an entry date of 03/04/2025. The MDS assessment in Section Z0500B was signed completed on 03/25/2025, which indicated the MDS assessment for Resident #10 was completed 8 days late. During an interview on 06/11/2025 at 10:21 AM, the MDS Coordinator said Resident #10's MDS assessment was signed late. The MDS Coordinator said she did not know why it was not signed completed. The MDS Coordinator said the DON had to sign them complete because she was not an RN. She said she tried to e-mail the DON and let her know which MDS assessments she needed to sign. The MDS Coordinator said she had two different buildings she was at, and she was only at the facility two days a week. When she was at the facility, she checked to ensure the MDS assessments were signed by the DON. The MDS Coordinator said she did not think the MDS assessments being signed late could really cause anything. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2025 at 1:55 PM, the DON said she tried to check every morning to see if there were any MDS assessments she needed to sign. The DON said sometimes they were things going on in the facility, and she was unable to check daily. The DON said sometimes the MDS Coordinator emailed her to tell her she needed to sign MDS assessments. The DON said she was not aware of the required timeframes for the MDS assessments. The DON said she did not remember signing anything late, and she did not know why Resident #10's admission MDS assessment was signed late. The DON said it was important for the MDS assessments to be completed within the required timeframes because it was important for the care the residents were provided to be captured in a timely manner. During an interview on 06/11/2025 at 2:58 PM, the Administrator said he expected that the MDS assessments were completed and signed on time. The Administrator said the MDS Coordinator and the RN signing the MDS assessments should be making sure they were signed timely. The Administrator said it was important for the MDS assessments to be completed per the required timeframes because it could affect their payment. The Administrator said he was not aware how this could directly affect the residents because he was not clinical. Record review of the facility's undated policy titled, Resident Assessment Policy, indicated, Completing the MDS 1) A registered nurse will coordinate each assessment with the appropriate participation of health professionals, and shall sign to certify the completion of each assessment in item Z0500. Each resident will be scheduled for an assessment period in which data will be gathered about the resident; with the frequency and type of assessment being determined according to the guidelines in the RAI Manual. Comprehensive assessments will be completed not less often than once every 12 months (366 days), within 14 calendar days after admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 2 residents (Residents #23 and Resident #24) reviewed for care plans. 1.The facility failed to ensure Resident #23 had her fall mat in place while in bed. 2. The facility failed to ensure Resident #24's care plan included the use of the antidepressant medication. These failures could have placed residents at risk for not having their needs met. Findings included: 1.Record review of Resident #23's face sheet dated 06/10/25 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses dementia, chronic kidney disease, anxiety, and high blood pressure. Record review of Resident #23's quarterly MDS dated [DATE] indicated she understood others and was able to make herself understood. The MDS also indicated she had a BIMS score of 10 which meant she had moderate cognitive impairment. The MDS also indicated she required limited assistance with transfers, extensive assistance with dressing, toileting, and showering, and setup for eating. The MDS also indicated Resident #23 had had a fall with no injury. Record review of Resident #23's care plan dated 02/10/25 indicated she had an actual fall on 02/07/25 attempting to transfer herself with interventions in place to have a floor mat in use when she was in bed. During an observation on 06/09/25 at 10:25 AM Resident #23 was laying in her bed and the fall mat was folded by the chair at the end of the bed. During an observation on 06/10/25 at 08:26 AM Resident #23 was in bed and had her fall mat folded beside the chair. During an interview on 06/11/25 at 01:04 PM CNA said she did not usually work on that side of the facility where Resident #23 resided but she had placed the fall mat down for Resident #23 before. She said Resident #23 had been known to move the mat when she transferred herself but was unsure of why the fall mat had not been in use. During an interview on 06/11/25 at 01:14 PM the DON said she expected the fall mat to be on the floor beside Resident #23's bed while she was in bed. The DON said Resident #23 had moved the floor mat in the past and she got upset at the staff when they placed the floor mat and made them remove the fall mat. The DON said not having the fall mat in place placed a risk for Resident #23 to have an injury if she had a fall from the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 02:11 PM The Administrator said he expected Resident #23's fall mat to be on the floor beside her bed and if it was not then there should have been documentation for the reasoning of why it was not in place. The Administrator said all nursing staff were responsible for ensuring the fall mat was in place. The Administrator said the failure placed Resident #23 at risk for injury from falls. 2.Record review of Resident #24's face sheet dated 06/11/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses dementia, retention of urine, heart failure, and high blood pressure. Record review of Resident #24's quarterly MDS dated [DATE] indicated he made himself understood and was able to understand others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated Resident #24 had taken antidepressant medication while in the facility. Record review of Resident #24's care plan dated 04/04/25 did not indicate Resident #24 was taking an antidepressant medication. Record review of Resident #24's order summary report dated 06/11/25 indicated he had an order for: Citalopram Hydrobromide oral tablet 10mg Give 1 tablet by mouth one time a day for depression with a start date of 04/10/25. During an interview on 06/11/25 at 01:17 PM the DON said Resident #24's care plan should have included the resident was taking an antidepressant medication. The DON said the DON, ADON, and the MDS nurse were all responsible for ensuring the resident care plans were completed with all diagnoses and medications pertinent to each resident. The DON said the failure of the antidepressant not being on his care plan placed a risk for staff not knowing Resident #24 had depression, the medication he was taking, or if he had any triggers. During an interview on 06/11/25 at 02:13 PM The Administrator said he would expect the antidepressant to be in Resident #24's care plan. He said all nursing staff were responsible for ensuring the care plans were completed and accurate. The Administrator said the failure placed a risk for the staff not knowing Resident #24 had depression and how to care for him. Record review of the facility policy Care Plans, Comprehensive Person-Centered revised December 2016 indicated: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation:1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents environment remained as free of accident hazards as was possible for 1 of 13 residents (Resident #7) reviewed for accident hazards. The facility failed to ensure the meyer's cleaner in Resident #7's room was properly stored. These failures could place residents at risk for injuries. Findings included: Record review of Resident #7's face sheet dated 06/10/25 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses heart failure (chronic disease in which the heart does not pump as it should), diabetes (disease causing high or low blood sugar levels), glaucoma (disease causing poor vision), kidney failure, anxiety, and high blood pressure. Record review of Resident #7's quarterly MDS dated [DATE] indicated he usually understood others and was able to make himself understood. The MDS also indicated he had a BIMS score of 11 which meant he had moderate cognitive impairment. The MDS also indicated Resident #7 required total assistance with toileting, dressing, transfers, and bathing, and he required setup for eating. Record review of Resident #7's care plan dated 05/10/24 indicated he required medication management with the intervention for staff to administer medication as prescribed by physician. The care plan also indicate Resident #7 required total assistance of 2 staff with toileting and transfers, and he required substantial/maximal assistance of 1 staff for dressing, bed mobility, bathing, and eating. During an observation and interview on 06/09/25 at 10:33 AM Resident #7 had a blue bottle of meyer's cleaner sitting on the bedside table. RN A said Resident #7's family member brought things he should not have in. RN A said the cleaner was something residents should not have in the rooms. She said the failure placed a risk for Resident #7 and other residents getting a hold of the cleaner and drinking it. During an interview on 06/10/25 at 10:42 AM The DON said Resident #7 should not have meyer's cleaner in his room, but the facility had issues with Resident #7's family member bringing items in the facility. She said the staff should have been aware of those items left in the rooms and removed them. The DON said the failure placed a risk for Resident #7 and other residents ingesting the cleaner. During an observation on 06/10/25 at 08:40 AM Resident #7 had a blue bottle of meyer's cleaner sitting on the bedside table. During an interview on 06/11/25 at 01:58 PM The Administrator said the facility did not have a policy for hazardous items in the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 02:06 PM The Administrator said he expected the cleaner to not be left in the residents' rooms. He said all staff should be responsible for ensuring the items were not left in the residents' rooms. The Administrator said the failure placed the risk for Resident #7 and another resident getting the cleaner and ingesting it. Record review of the facility policy Accidents and Incidents revised July 2020 did not indicate cleaners or storage of hazardous items.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 of 13 residents reviewed in sample (Resident #7 and Resident #11). 1.The facility failed to ensure Resident #7 did not have prescribed wound cleanser and non-prescribed buttocks powder left at bedside on the dresser. 2.The facility failed to ensure Resident #11 did not have artificial tears on his bedside table. These failures could place residents at risk of injury. Findings included: 1.Record review of Resident #7's face sheet dated 06/10/25 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses heart failure (chronic disease in which the heart does not pump as it should), diabetes (disease causing high or low blood sugar levels), glaucoma (disease causing poor vision), kidney failure, anxiety, and high blood pressure. Record review of Resident #7's quarterly MDS dated [DATE] indicated he usually understood others and was able to make himself understood. The MDS also indicated he had a BIMS score of 11 which meant he had moderate cognitive impairment. Record review of Resident #7's care plan dated 05/10/24 indicated he required medication management with the intervention for staff to administer medication as prescribed by physician. Record review of Resident #7's order summary report dated 06/10/25 indicated he had an order for: Toenail infection to right first toe: Cleanse with wound cleanser, pat dry apply betadine and triple antibiotic ointment and leave open to air daily one time a day with a start date of 04/23/25 and no end date. The order summary did not indicate an order for buttocks powder. During an observation on 06/09/25 at 10:33 AM Resident #7 had a plastic container labeled Resident #7 buttocks with white powdery substance in it sitting on his dresser beside the bed. During an observation on 06/10/25 at 08:40 AM Resident #7 had a bottle of wound cleanser at bedside and a plastic container labeled Resident #7 buttocks with white powdery substance in it sitting on his dresser by his bed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #11's face sheet dated 06/10/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses metabolic encephalopathy (a brain disorder caused by chemical imbalances in the body), congestive heart failure (chronic disease in which the heart does not pump as it should), high blood pressure, and depression. Record review of Resident #11's admission MDS dated [DATE] indicated he made himself understood and was able to understand others. The MDS also indicated he had a BIMS score of 13 which meant he was cognitively intact. Record review of Resident #11's care plan dated 05/12/25 indicated he was at risk for substance abuse, and he had heart disease with interventions to administer medication per physician orders. Record review of Resident #11's order summary report dated 06/10/25 did not indicate Resident #11 had an order for artificial tears. During an observation and interview on 06/10/25 at 08:26 AM during medication administration Resident #11 had a bottle of natural tears eye drops sitting on his bedside table. Resident #11 said he used the naturl tears when he needed them. During an interview on 06/10/25 at 09:15 AM LVN F said Resident #11 had always had the artificial tear eye drops at his bedside. She said he never asked to administer the eye drops. LVN F said she had a few residents that could self-administer but she was unsure if Resident #11 was one of those residents because she always administered his medication. During an observation on 06/10/25 at 01:15 PM Resident #11 had artificial tears eye drops sitting on his bedside table. During an observation and interview on 06/10/25 at 10:42 AM The DON said Resident #11 nor Resident #7 were not one of the residents who had an assessment completed for self-administering medications and he should not have his eye drops in the room. The DON removed the eye drops. The DON said the failure placed risk for other residents getting the medications or Resident #11 improperly taking the medication. The DON said she had several talks with Resident #7's family member about him not being able to keep medications or cleaners at bedside. During an interview on 06/11/25 at 02:06 PM The Administrator said he expected the medications to not be left in the residents' rooms. He said all staff should be responsible for ensuring the items were not left in the residents' rooms. The Administrator said the failure placed the risk for any of the residents, including Resident #7 and Resident #11, getting the medication and ingesting it. Record review of the facility policy Volume I-Policies and Procedures for Pharmacy Services undated indicated: 6.Delivery, Receipt and Storage of Medication .6.3 Storage of Medication: The facility should ensure that only authorized facility staff should have access to medication storage areas .Scheduled medications should be stored in a separate locked area with the medication carts or medication room.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 3 of 13 residents (Resident #2, Resident #29, and Resident #188) reviewed for laboratory services. The facility failed to obtain Resident #2's CMP (lab test that provides an overall picture of your body's chemical balance and metabolism, and can help diagnose, screen for, or monitor health conditions or medication side effects) as ordered. The facility failed to obtain Resident #29's CBC (used to monitor and diagnose medical conditions, check the health of the immune system, and detect disorders including infections, anemia, and blood cancer) and CMP as ordered. The facility failed to obtain Resident #188's urinalysis (urine test that can help find problems that need treatment, including infections or kidney problems, and can also detect serious diseases in the early stages) as ordered. These failures could place residents at risk of not receiving timely diagnoses, treatment, and services to meet their needs. Findings included: 1. Record review of Resident #2's face sheet dated 06/11/2025 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (condition that affects blood flow to the brain), essential primary hypertension (high blood pressure), hypothyroidism (condition where the thyroid gland does not produce enough hormones), and prediabetes (condition where blood sugar levels are higher than normal but not high enough to be diabetes). Record review of the MDS assessment indicated Resident #2 was understood by others and understood others. The MDS assessment indicated Resident #2 had a BIMs score of 15, which indicated her cognition was intact. Record review of the Order Summary Report dated 06/11/2025 indicated Resident #2 had an order for a Comprehensive Metabolic Panel (CMP) on admission and every 3 months with an order date of 04/05/2024. Record review of Resident #2's care plan did not address obtaining labs. Record review of Resident #2's electronic health record indicated her CMP was last collected 01/20/2025. 2. Record review of Resident #29's face sheet dated 06/11/2025 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Parkinson's disease without dyskinesia without mention of fluctuations (progressive disorder that affects the nervous system and the parts of the body controlled by nerves without any involuntary muscle movements), hyperlipidemia (high cholesterol), and chronic kidney disease (condition that affects the kidneys and can lead to kidney failure). (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #29 was usually understood by others and usually understood others. The MDS assessment indicated Resident #29 had a BIMS score of 8, which indicated his cognition was moderately impaired. Record review of Resident #29's Order Summary Report dated 06/11/2025 indicated an order for a CBC and a CMP every 3 months with a start date of 12/31/2023. Record review of Resident #29's care plan with a target date of 08/05/2025 indicated Resident #29 had a potential nutritional problem to obtain and monitor lab/diagnostic work as ordered. Record review of Resident #29's electronic health record indicated his CBC and CMP were last collected on 01/08/2025. 3. Record review of Resident #188's face sheet dated 06/11/2025 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Parkinson's disease without dyskinesia without mention of fluctuations (progressive disorder that affects the nervous system and the parts of the body controlled by nerves without any involuntary muscle movements) and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate with symptoms such as difficulty urinating). Record review of Resident #188's electronic health record on 06/11/2025 indicated his admission MDS assessment was in progress. Record review of Resident #188's Order Summary Report dated 06/11/2025 indicated an order for a urinalysis with a start date of 05/31/2025. Record review of Resident #188's care plan date initiated 05/31/2025 indicated he used a mood stabilizer/anticonvulsant (medication used to prevent seizures) medication to obtain labs as ordered. Record review of Resident #188's electronic health record did not indicate urinalysis results from 05/31/2025. Record review of the facility's 24-hour report from 05/30/2025- 06/09/2025 indicated: 05/30/2025 no notes regarding Resident #188's urinalysis. 05/31/2025 no notes regarding Resident #188's urinalysis. 06/01/2025 no notes regarding Resident #188's urinalysis. 06/02/2025 for the 2 PM-10 PM shift Resident #188's urinalysis needed. 06/03/2025 6 AM-2 PM shift Resident #188's urinalysis needed. 06/04/2025 2 PM-10 PM shift Resident #188's urinalysis needed. 06/05/2025 no notes regarding Resident #188's urinalysis. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/06/2025 no notes regarding Resident #188's urinalysis. 06/07/2025 2 PM-10 PM shift Resident #188's urinalysis needed. 06/08/2025 6 AM-2 PM shift Resident #188's urinalysis needed. 06/09/2025 10 PM-6 AM shift urine was collected for urinalysis. During an interview on 06/10/2025 at 1:47 PM, RN A said Resident #188's urinalysis was an admission order. RN A said the lab did not collect specimens over the weekend. RN A said Resident #188's urine should have been collected and sent out on Monday 06/02/2025. RN A said she attempted to collect Resident #188's urine on Monday but was unable to because she could not get him to use a urinal or sit on the commode. RN A said an in and out catheter could be used to collect the urine, if the resident did not refuse. RN A said she had not attempted an in and out catheter. RN A said she passed it on in report to LVN C that she was not able to obtain the urine specimen for the urinalysis, and she did not know why it was not collected. RN A said it was important for the urinalysis to be collected because the residents could have an infection or bacteria that needed to be treated. During an attempted phone interview on 06/10/2025 at 3:37 PM, LVN C did not answer the phone. During an attempted phone interview on 06/11/2025 at 8:46 AM, LVN C did not answer the phone. During an interview on 06/11/2025 at 11:44 AM, RN B said she admitted Resident #188 and she put the order in for his urinalysis. RN B said she did not work the following days, and Resident #188's urine should have been set out on Monday, 06/02/2025. RN B said when she returned to work on Wednesday, 06/04/2025, she was under the impression his urine had been collected because she was not told it needed to be collected and sent out. RN B said if a lab is not collected it should be placed on the 24-hour report until it was collected. RN B said it was important to collect labs so they could have a baseline and know how to treat the residents. During an interview on 06/11/2025 at 1:37 PM, the DON said Resident #2 and Resident #29's labs were collected in January 2025. The DON said the labs were not drawn as ordered because she thought they had been discontinued. The DON said they changed medical directors, and their new medical director only wanted labs drawn yearly. The DON said the nurses should be ensuring the labs were drawn per the doctor's orders. The DON said the ADON and herself monitored the nurses to ensure all labs were drawn. The DON said she was not aware Resident #188's urinalysis was not completed after admission. The DON said if the nurses were having difficulty collecting Resident #188's urine they should have put it on the 24-hour report to ensure it was collected and sent out promptly. The DON said it was important to collect the residents' labs as ordered to ensure the residents did not have any abnormal labs or changes that they needed to treat. (continued on next page)

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	676477	A. Building B. Wing	06/11/2025

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Caraday of Mount Vernon	501 Yates Street Mount Vernon, TX 75457

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/11/2025 at 2:26 PM, the ADON said in the mornings the DON and herself conducted lab follow up with the charge nurses to ensure the labs were monitored. The ADON said Resident #2 and Resident #29's orders were old labs that were not taken out when they changed medical directors in March 2024. The ADON said this was why Resident #2 and Resident #29's labs were not completed. The ADON said Resident #188 admitted late Friday and the lab did not go to the facility on the weekends. The ADON said she was noticed by the charge nurse that she attempted to collect Resident #188's urine on Monday, and he refused. The ADON said nothing else was reported to her, and she did not know why it was not collected after that. The ADON said it was important for labs to be collected as ordered to monitor the residents for infections, medication monitoring, and to monitor disease processes. During an interview on 06/11/2025 at 2:57 PM, the Administrator said his expectations were for the labs to be completed timely. The Administrator said the floor nurses who received the lab orders should relay to the next shifts labs that needed to be collected. The Administrator said not following the residents' lab orders could affect the well-being of the residents because they had to know what to treat and how to treat it. Record review of the facility's policy titled, Lab and Diagnostic Test Results-Clinical Protocol, revised November 2018, indicated, 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The team will process test requisitions and arrange for tests.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to promptly notify and follow-up with the ordering physician regarding laboratory results outside of clinical reference range for 1of 20 residents (Resident #25) reviewed for laboratory services. The facility failed to respond to Resident #25's physician when he questioned Resident #25's Keppra (used to control seizures) dosage on 03/31/25. This failure could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level. Findings included: Record review of Resident #25's face sheet fated 06/10/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (stroke), seizures, and dementia (memory loss). Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident #25 was usually understood and usually understood others. Resident #25 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #25 had received an anticonvulsant medication within the last 7 days of the 7-day look back period. Record review of Resident #25's comprehensive care plan revised 05/10/24, indicated Resident #25 had a seizure disorder related to stroke. The care plan interventions indicated to give seizure medication as ordered by the doctor, monitor labs, and report any subtherapeutic or toxic results to the medical director. Record review of Resident #25's order summary report dated 06/10/25, indicated the following order: Keppra level in the AM with an order start date of 03/27/25. Keppra 100mg/ml give 10mls by mouth two times a day related to seizures with a start date of 05/17/25. Record review of Resident #25's lab result report dated 3/28/25, indicated Resident #25's Keppra level was 57.10 and was above the therapeutic range of 6.00-46.00. The report was electronically signed on 03/31/25 by the medical director where he wrote What is her current Keppra dose. Record review of the facility's 24-hour report dated 03/28/25, indicated Resident #25 was on skilled charting for 3 days. The report did not indicate Resident #25's lab results had been faxed to the doctor and required a follow up. Record review of the facility's 24-hour report dated 03/29/25, indicated Resident #25 was on skilled charting for 3 days. The report did not indicate Resident #25's lab results required a follow up. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's 24-hour report dated 03/30/25, indicated Resident #25's skilled charting was completed. The report did not indicate Resident #25's lab results required a follow up. Record review of the facility's 24-hour report dated 03/31/25, indicated Resident #25 was on skilled charting. The report did not reveal any new orders regarding Resident #25's Keppra. Record review of the facility's 24-hour report dated 04/01/25, indicated Resident #25 had a new order to change her vitamin D to 2000 units daily and increase the levothyroxine (medication used to treat thyroid hormone deficiency) to 75mcg every morning. The report did not reveal any new orders regarding Resident #25's Keppra. Record review of Resident #25's progress notes dated 03/10/25- 06/11/25 did not reveal Resident #25's Keppra lab result was addressed. The progress notes did not indicate Resident #25 had any seizures. Record review of Resident #25's nursing MAR for the month of April 2025, indicated she received Keppra 100mg/ml 10 mls via her peg tube (tube inserted in the stomach for medications and nutrition) two times a day. The MAR did not indicate any Keppra doses had been held or refused. During an interview on 06/10/25 at 1:40 PM, the DON said no one ever responded to Resident #25's doctor when he asked what her current Keppra dosage was. She said LVN D worked on 03/31/25 and was responsible for following up on the labs. She said there was nothing charted in Resident #25's progress notes to indicate the lab was addressed. She said if it was not charted it was not done. The DON said since Resident #25's lab was not addressed she could have had a seizure. The DON said Resident #25 had not had any seizures. She said all nurses were responsible for following up on the lab results. She said nurse management discussed labs in the morning clinical meeting. The DON said somehow the ball was dropped on Resident #25's Keppra level. She said she was unsure of how Resident #25's lab was missed. The DON said Resident #25's Keppra lab was not written on the 24-hour report for follow up. During an interview on 06/10/25 at 5:32 PM, LVN D said she was unable to recall if she worked on 03/31/25. LVN D said if there was a lab she needed to follow up it would have been written on the 24-hour report. She said if it was not written on the 24 hour report she would not know if there was anything that needed to be addressed. She said if it had been discussed in clinical then it would have been addressed and charted. She said the nurse email was checked every shift for lab results and faxes. She said by not responding to the doctor regarding her Keppra order placed Resident #25 at risk for having an adverse reaction to an elevated Keppra level. She said Resident #25 could have had a seizure. She said any labs awaiting a response from the doctor were attached to the 24-hour report. During an interview on 06/11/24 at 12:45 PM, the Administrator said he expected the nurse to follow up with labs immediately once they were received. He said he was not medical and did not know the risk of not notifying the physician on Resident #25's Keppra dosage. He said the DON was responsible for ensuring all labs were being followed up on. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Lab and Diagnostic Test Results- Clinical Protocol revised November 2018, indicated . 1. When test results are reported to the facility, a nurse will first review the results. A. if a team member who first received or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow coordinate the procedure . 2. High or toxic serum medication levels. If a test was obtained to monitor the blood level of a medication and the level is reported as high (above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 2 residents (Residents #25) reviewed for hospice services. The facility failed to obtain Resident #25's most recent updated hospice plan of care and hospice nursing visit notes. This deficient practice could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of Resident #25's face sheet fated 06/10/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (stroke), seizures and dementia (memory loss). Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident #25 was usually understood and usually understood others. Resident #25 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #25 received hospice care. Record review of Resident #25's comprehensive care plan revised 01/06/25, indicated Resident #25 was receiving hospice services with interventions to monitor for decreased appetite, weight loss, skin breakdown, nausea/vomiting, etc. report to hospice. Record review of Resident #25's order summary report dated 06/10/25, indicated the following order: Admit to [Hospice] with diagnoses of late effects of cerebrovascular accident with a start date of 12/24/24. Record review of Resident #25's hospice binder revealed the following: RN Visit note dated 05/06/25. Hospice plan of care update dated 05/09/25. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 10:15 AM, the Hospice DON said the updated hospice documents should be taken to the facility every 2 weeks following the hospice IDT meeting. She said the Hospice Case Manager, or the Office Manager were responsible for ensuring the hospice documents were being taken to the facility. She said the Assistant Office Manager was out on personal leave and why the hospice documents were not brought since last month. She said the Office Manager probably had not realized the Assistant Office Manager had not taken the hospice documents since last month. The Hospice DON said the most recent hospice documents should be at the facility so the facility was aware of any changes to the plan of care that was done during the IDT meeting. She said Resident #25's case manager was currently on vacation and unavailable for interview. During an interview on 06/11/25 at 12:23 PM, the DON said she expected the most recent hospice documents to be updated and in the resident's hospice binder. She said the hospice office personnel and the hospice nurses were responsible for ensuring the hospice documents were being brought to the facility. She said failure to have Resident #25's most recent hospice documents placed the resident at risk for not being aware of any changes the resident might have had. During an interview on 06/11/24 at 12:45 PM, the Administrator said he expected the hospice documents to be brought to the facility in a timely manner. He said the hospice nurse or a representative from the hospice company was responsible for ensuring the hospice documents were being brought to the facility timely. He said failure to have the most recent hospice documents could place the resident at risk of receiving improper care. Record review of the nursing facility hospice contract dated October 22, 2021 between the facility and the Resident #25's hospice indicated . information/documentation provided to facility on admission and on-going: 1. Most recent hospice plan of care . 6. Copies of clinical notes after each visit .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Record review of Resident #7's face sheet dated 06/10/25 indicted he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses heart failure(chronic disease in which the heart does not pump as it should), diabetes (disease causing high or low blood sugar levels), glaucoma (disease causing poor vision), kidney failure, anxiety, and high blood pressure. Record review of Resident #7's quarterly MDS dated [DATE] indicated he usually understood others and was able to make himself understood. The MDS also indicate he had a BIMS score of 11 which meant he had moderate cognitive impairment. The MDS also indicated Resident #7 had a foley catheter and skin treatments. Record review of Resident #7's care plan dated 04/01/24 indicated he required enhanced barrier precautions with interventions in place for the staff to use PPE for high contact care activities and indications: wounds, indwelling, medical device, infection, and for the staff to follow enhanced barrier precautions per facility policy. During an observation 06/10/25 at 10:06 AM, RN A entered Resident #7's room and provided wound care and failed to put on an isolation gown prior to care being provided. During an interview on 06/10/25 at 10:33 AM, RN A said she should have put on a gown and gloves prior to providing wound care for the Resident #7. She said Resident #7 required enhanced barrier precautions for his catheter care and wound care. RN A said enhanced barrier precautions was used for catheter care, wound care, gastrostomy tubes, and tracheostomy care. She said the failure placed an increased risk for infection. During an interview on 06/11/25 at 01:12 PM, the DON said all staff should be using the proper PPE when enhanced barrier precautions were in place The DON said herself and the ADON were responsible for ensuring the staff was using the proper PPE with care. The DON said the failure of not using PPE placed residents at an increased risk for infection. During an interview on 06/11/25 at 02:09 PM, the Administrator said his expectation was for all nurses to use the proper PPE when enhanced barrier precautions were in place. He said the DON and the ADON were responsible for ensuring the staff used proper PPE when providing care. The Administrator said the failure place and increased risk for contamination. Record review of the facility's policy Handwashing/Hand Hygiene revised August 2019, indicated . This facility considers hand hygiene the primary means to prevent the spread of infections . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. After removing gloves .9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Enhanced Barrier Precautions dated August 2022 indicated: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy and Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention .2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Residents #25 and #7) reviewed for infection control practices. 1. The facility failed to ensure CNA E performed hand hygiene after she changed her gloves during Resident #25's incontinent care on 06/10/25. 2. The facility failed to ensure RN A used the proper PPE for enhanced barrier precautions during wound care for Resident #7. These failures could place residents and staff at risk for cross contamination and the spread of infection. Finding include: 1.Record review of Resident #25's face sheet dated 06/10/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (stroke), seizures and dementia (memory loss). Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident #25 was usually understood and usually understood others. Resident #25 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #25 was dependent on facility staff with all ADLs and was always incontinent of urine and bowel. Record review of Resident #25's comprehensive care plan revised 05/10/24, indicated Resident #25 was incontinent of bowel and bladder with interventions to check resident every 2 hours and as needed for incontinence. During an observation and interview on 06/10/25 at 10:52 AM, CNA E entered Resident #25's room to provide incontinent care. CNA E donned PPE. During the incontinent care process, CNA E failed to perform hand hygiene when she removed her dirty gloves and applied clean gloves. CNA E said she removed her gloves during the incontinent care process because she had poop on them. CNA E said she should have hand sanitized in between glove changes and forgot because she was nervous. CNA E said by not performing hand hygiene in between glove changes placed Resident #25 at risk for infections. CNA E said she was responsible for performing proper incontinent care and hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 12:23 PM, the DON said she expected hand hygiene to be performed after each glove change for infection control. She said failure to perform hand hygiene could place the residents and staff at risk for infections. The DON said the person providing the care was responsible for ensuring proper hand hygiene was being performed. During an interview on 06/11/24 at 12:45 PM, the Administrator said he expected hand hygiene to be performed between each glove change. He said by not performing hand hygiene the CNA could have introduced contaminates into the incontinent care process. The Administrator said the individual providing the care was responsible for ensuring proper hand hygiene was being performed. He said nurse management was responsible for providing infection control education.